MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

07991

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:

County: A. A. Co.

City or town: Hanover, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Hanover, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Ridge Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John C. Ackerman

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: ALTHA

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): DEC. 22, 1886

8. AGE: Years	Months	Days	If less than one day
61	7	17	hrs. min.

9. Birthplace: BALTIMORE, MARYLAND (Town, county, and state)

10. Usual occupation: SHOW BUSINESS

11. Industry or business

FATHER — 12. Name: J. H. V. ACKERMAN

FATHER — 13. Birthplace: NEW BRUNSWICK N.J.

MOTHER — 14. Maiden name: JOSEPHINE FELTER

MOTHER — 15. Birthplace: NEW BRUNSWICK N.J.

16. Informant: MRS. ALTHA ACKERMAN

Address: HANOVER, MARYLAND

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: AUG. 12, 1948 (month) (day) (year)

Cemetery or crematory: LOUDON PARK

Location: BALTIMORE, MARYLAND

18. Funeral director: WILLIAM COOK, INC.

Address: 1217 ST. PAUL ST.

19. 8/11/48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9th 1948 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 9 1948 to Aug. 9 1948 and that I last saw h[illegible] alive on Aug. 9 1948

Immediate cause of death	DURATION
Congestive Cardio-Vascular disease —	3 Mos.
Due to: Hypertension —	?
Due to:	
Other conditions: Emphysema —	?

(Include pregnancy within 3 months of death)

Major findings of operations: None

None. Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank Shipley, M.D.

M. D. or other

Address: Savage, Md. Date signed: 8/9/48.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07992

93 e

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

79 Washington St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 79 Washington St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Nannie Adams

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife George Adams

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 8 27 1882

8. AGE: Years	Months	Days	If less than one day
65	11	29	..... hrs. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name Lovelee Jones

13. Birthplace Rhode Island

MOTHER 14. Maiden name Alice Jones

15. Birthplace Baltimore, Md

16. Informant Mrs. Isaebell Lewis

Address 79 Washington St.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 8 29, 1948 (month) (day) (year)

Cemetery or crematory Cemetery

Location Northwest St. Anna. Md.

18. Funeral director William Reese 11

Address 108 Washington St.

19. Aug. 28 1948 (Date rec'd by registrar) Wm Tomich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1948, at 3 30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 7, 1947 1948, to ~~Aug~~ Aug 26 1948 and that I last saw h.. alive on ~~Aug~~ Aug 25 1948

Immediate cause of death Congestive Heart failure — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address 10 Church Date signed 8-27-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07993

97

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 6 mos.

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 1 yr. 6 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1008 Gay Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: CHARLOTTE ANDERSON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife: ---

6.(c) If alive, give age? ---- years

7. Birth date of deceased (mo., day, yr.): (unknown) 1868?

8. AGE: Years: 80? Months: Days: If less than one day: ....hrs. ....min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: ---

FATHER

12. Name: Jefferson Miles

13. Birthplace: Pennsylvania

MOTHER

14. Maiden name: Lucinda Miles

15. Birthplace: Pennsylvania

16. Informant: Hospital Records

Address: Crownsville, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 8/31/48 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18 Funeral director: Dept Hospl.

Address: Crownsville Md

19. 8/31/48 E F Joyce Local Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25 19 48, at 5:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14 19 47, to August 25 19 48

and that I last saw her alive on August 25 19 48

Immediate cause of death: General Arteriosclerosis — DURATION: 3/14/47

known to us since

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op. ---

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Jacob Marquardt M. D. M. D. or other

Address: Crownsville, Maryland Date signed 8/25/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d Bc 07994

Reg. Dist. No. 28

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs. 1 mo.
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 7 yrs. 1 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: —
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4 W. Churchill St.
(If rural, give LOCATION)
—
2.(a) If veteran, name war:

3. (a) FULL NAME: HARRY ANDERSON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	Negro	Married

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): 1879

8. AGE: Years	Months	Days	If less than one day
69			...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: preacher
11. Industry or business: ———

FATHER
12. Name: John C. Anderson
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Mary Anderson
15. Birthplace: Grinage, Md.

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?). Date thereof 8-9-48 (month) (day) (year)
Cemetery or ~~crematory~~: Hospital
Location: Crownsville Md

18. Funeral director: Hosp Hospital
Address: Crownsville

19. 8/9-48 (Date rec'd by registrar) E. F. Jayne Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5 19 48 at 4:35a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1941, to August 5 1948 and that I last saw him alive on August 5 1948

Immediate cause of death: Chronic Myocarditis known to us since — DURATION 7/9/41

Due to:

Due to:

Other conditions: Psychosis with Cerebral Arteriosclerosis known to us since 7/9/41
(Include pregnancy within 3 months of death)

Major findings of operations: ———
Date of op. ———

Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ———
Means of injury: ——— Injured at work?

23. SIGNATURE: Jacob Marycuster M.D.
Address: Crownsville, Md. M. D. or other 8/5/48 Date signed

07995

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

48 b

Reg. Diat. No. 20

1. PLACE OF DEATH:
County Anne Aurndel
City or town Deale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos.
Hospital, institution, or street address where death occurred:
Deale, A. A. Co., Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Anne Arundel
City or town Deale
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) Ti veteran, name war No

3.(a) FULL NAME
PEARL OLEVIA ANDERSON

3.(b) Social Security Number
no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Russell H. Anderson
6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) August 23, 1894

8. AGE: Years	Months	Days	If less than one day
53	11	29	hrs. min.

9. Birthplace Nutwell, Maryland
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

FATHER
12. Name don't know
13. Birthplace Maryland

MOTHER
14. Maiden name ? Tydings
15. Birthplace Maryland

16. Informant Russell H. Anderson
Address Deale, Maryland

17. Burial Date thereof Aug. 25, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Ft. Lincoln
Location Washington Blvd., Md.
18. Funeral director Ritchie Bros.
Address Upper Marlboro, Md.

19. 8/24 48 (Date rec'd by registrar) J.M. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sun. August 22 1948 at 5:10 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1948 to August 22 1948 and that I last saw her alive on August 10 1948

Immediate cause of death	DURATION
glioblastoma carcinoma	
Due to carcinoma uterus ?	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Emily H. Wilson, M.D.
M. D. or other
Address Lothian, Md. Date signed 8/24/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07995

97

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Ferndale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred: Hallers Dairy Road.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No.: Same

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME George Thomas Barnes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Colored.	Widowed.

6.(b) Name of husband or wife: Louise Maria Bowie

6.(c) If alive, give age: dead years

7. Birth date of deceased (mo., day, yr.): July 30 - 1880

8. AGE: Years: 68 Months: 1 Days: 26 If less than one day: hrs. min.

9. Birthplace: Elkridge, Md. (Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business:

FATHER — 12. Name: George T. Barnes

13. Birthplace: Maryland.

MOTHER — 14. Maiden name: ?

15. Birthplace: ?

16. Informant: Rachel Lewis (daughter)

Address: Ferndale, Md.

17. (Burial, cremation, or removal. Which?) Date thereof: Aug 31 1948 (month) (day) (year)

Cemetery or crematory: St. Rest (Saints Rest)

Location: Harmons, Md.

18. Funeral director: Mrs Katie R Williams

Address: 322 W Lanvale St

19. 8/31 19 (Date rec'd by registrar) L J Obrella Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 28 1948 at 11:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 — to — 19 —

and that I last saw h alive on — 19 —

	DURATION
Immediate cause of death: Cerebral Arteriosclerosis	
Due to: Senility	?
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Gustave H. Gaubert M.D.

Attending Medical Coroner or other

Address: Glen Burnie, Md. Date signed: 8/29/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07998

173

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above piece of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Kansas County:
City or town: Meade
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Box 172
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: BARNETT, George Calvin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Single

6.(b) Name of husband or wife: Not married
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6-24-24

8. AGE: Years: 24 Months: 2 Days: 1 If less than one day: hrs. min.

9. Birthplace: Wichita, Kansas
(Town, county, and state)

10. Usual occupation: US Navy

11. Industry or business

FATHER
12. Name: Not available
13. Birthplace

MOTHER
14. Maiden name: Not available
15. Birthplace

16. Informant: US Navy records
Address

17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof: 8-27-48 (month) (day) (year)
Cemetery or cremetory
Location: MEADE, KANSAS

18. Funeral director: B. L. HOPPING & SON
Address ANNAPOLIS MARYLAND

19. Aug 27 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 August 1948 about 2-45 P.M.

21. I CERTIFY that death occurred on the date above stated: [redacted]
Post mortem Examination [redacted] Aug. 25 1948

Immediate cause of death	DURATION
3rd. degree burns	
Due to: of entire body	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 8-25-48
Where did injury occur? near Annapolis (City or town) A. A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?): Trumpy's Farm
Means of injury: Air-plane collision Injured at work? No

23. SIGNATURE: John M. Caffey M.D. Deputy medical Examiner M. D. or other
Address: Annapolis, Md. Date signed: 8-26-48

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and forcibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

07993

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Marley Park (Glen Burnie, Md)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 ½ Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Marley Park, (Glen Burnie, Md)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Holloway Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: RUTH ADELE BIDDINGER

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: J. Franklin Biddinger

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): November 12, 1911

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
36	8	28		

9. Birthplace: Hartville, North Carolina
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: William T. Odom
13. Birthplace: Darlington, South Carolina

MOTHER
14. Maiden name: Marry Johnson
15. Birthplace: Darlington, South Carolina

16. Informant: J. Franklin Biddinger
Address: Holloway Road

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Aug. 13, 1948 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Baltimore, Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. 8/12 1948 (Date rec'd by registrar) L. J. DeAlba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10 1948, at 5:05p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APRIL 1946, to AUGUST 1948 and that I last saw h[illegible] alive on AUGUST 10 1948

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	
Due to: HYPERTENSION, MALIGNANT STATE	
Due to: CAUSE UNKNOWN	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry F. Zangara, M. D.
M. D. or other

Address: Glen Burnie, Md. Date signed: Aug 12, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08000

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yrs. 11 mos.

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 1 yr. 11 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 612 Franklin St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I. ✓

3. (a) FULL NAME: JAMES BONNER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife: -----

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): July 1898

8. AGE: Years: 50 | Months: | Days: | If less than one day: ...hrs. ...min.

9. Birthplace: Virginia - Surrey County
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ---

FATHER
12. Name: David Bonner
13. Birthplace: Virginia

MOTHER
14. Maiden name: Ann Tucker
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 27, 1948 (month) (day) (year)

Cemetery or crematory: Mt. Auburn Cemetary

Location: Baltimore, Md.

18 Funeral director: Mrs. Katie Williams

Address: 322 N. Schroeder St.

19. 8/27 19 48 A. W. Hedrick Registrar
(Date rec'd by registror)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22 1948, at 4:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 20 1946, to August 22 1948

and that I last saw him alive on August 22 1948

	DURATION
Immediate cause of death: General Paresis known to us since	9/20/46
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: -----

Date of op.: ----

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ---

Accident, suicide, or homicide: --- Date of ...

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury: ---- Injured at work? ---

23. SIGNATURE: Jacob Carpenter M.D.
M. D. or other

Address: Crownsville, Maryland Date signed: 8/22/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

54b-Bc 08001

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Sherwood Forest
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Balto.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 104 St. John's Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: None ✓

3. (a) FULL NAME: DOUGLAS PAINTER BOWYER

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	SINGLE

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 14, 1939

8. AGE:

Years	Months	Days	If less than one day
8	10	28	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Dr. Thomas S. Bowyer
13. Birthplace: Va.

MOTHER
14. Maiden name: Ernestine Schmidt
15. Birthplace: Balto. Md.

16. Informant: Mr. Carl Schmidt
Address: Carey & Laurens Sts.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/14/48 (month) (day) (year)

Cemetery or ~~crematory~~: Loudon Park

Location: Baltimore, Md.

18. Funeral director: WM. J. TICKNER & SONS INC.

Address: North & Pa. Aves. Balto. 17, Md.

19. 8/13 (Date rec'd by registrar) 19 48 A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 12, 1948, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1947 to Aug 1948 and that I last saw him alive on July 1948

Immediate cause of death	DURATION
Brain Tumor (Malignant)	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Brain Tumor (Malignant) Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Richard G. Corbett M. D. or other

Address: Latrobe Apts. Date signed: 8/13/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08002

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred: 91 market
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(Never born infants give residence of mother)
State: Maryland County: Calvert
City or town: Barstow
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George Ridgley Boyd.

3.(b) Social Security Number

4. Sex: male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 9, 1912

8. AGE: Years: 36 Months: 3 Days: 20 If less than one day: hrs. min.

9. Birthplace: Calvert Co. Maryland
(Town, county, and state)

10. Usual occupation: Tax Cosultnant

11. Industry or business

FATHER
12. Name: George Boyd
13. Birthplace: Maryland

MOTHER
14. Maiden name: Effie Hardesty
15. Birthplace: Maryland

16. Informant: Mr. George Boyd
Address: Barstow, Calvert Co., Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof September 1, 48 (month) (day) (year)
Cemetery or crematory: WESLEY M.E. Cemetery
Location: PRINCE FREDERICK Barstow Calvert Co. Maryland

18. Funeral director: A.A. Harkness and Son
Address: Mutual, Calvert Co. Maryland

19. Aug. 29 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 29 1948 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Postmortem Examination and that I last saw him alive on Aug. 29 1948

	DURATION
Immediate cause of death: Coronary occlusion	Sudden
Due to: Coronary sclerosis	natural
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John N. Caffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 8-29-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157 e

CERTIFICATE OF DEATH

Reg. Dist. No. 08003

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Harundale (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: 2002 Norman Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Harundale (If outside city or town limits, write RURAL and give nearest town)
Street No. 2002 Norman Road (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: RAY CLINTON BOYD
3. (b) Social Security Number: NONE

4. Sex: M.
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: SINGLE
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): May 26, 1947

8. AGE: Years: 1 Months: 2 Days: 10 If less than one day ... hrs. ... min.

9. Birthplace: Coronado, California (Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name: Raymond A. Boyd
13. Birthplace: Pocohantus, Iowa

MOTHER
14. Maiden name: Eda Helen Woodruff
15. Birthplace: Idaho

16. Informant: Raymond A. Boyd
Address: 2002 Norman Road, Harundale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 10, 1948 (month) (day) (year)
Cemetery or crematory: U. S. Naval Academy
Location: Annapolis, Maryland
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Maryland

19. 8/9 1948 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/6/ 1948 at 8:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw him alive on 8/5 - 8/6 1948

	DURATION
Immediate cause of death: Acute ~~[struck]~~ pulmonary edema	
Due to: cardiac failure	
Due to: congenital malformation of heart	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results: Pulmonary edema, Cardiac failure, [illegible]

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Dr. Paul Tinker / John T. [illegible] MD, M. D. or other
Address: Glen Burnie, Md. Date signed: 8/7/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

U8004

55e

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County A. A.
City or town Waterbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A. A.
City or town Waterbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles Henry Bradford.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Jeanette Bradford. 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11 1898

8. AGE: Years 49 | Months 8 | Days 21 | If less than one day hrs. min.

9. Birthplace Waterbury, Md.
(Town, county, and state)

10. Usual occupation Labor

11. Industry or business

FATHER 12. Name James Bradford

13. Birthplace Md

MOTHER 14. Maiden name Elizabeth Thomas

15. Birthplace Md

16. Informant Jeanette Markell

Address Waterbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 2 1948 (month) (day) (year)

Cemetery or crematory John Wesley

Location Waterbury Md

18. Funeral director E. T. Joyce

Address Annapolis Md.

19. Aug. 30. 1948 (Date rec'd by registrar) E. T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1948 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1948 to Aug 29 1948 and that I last saw h...m alive on Aug 29 1948

Immediate cause of death	DURATION
Generalized Carcinomatosis	6 mo
By inference, but not proven, primary	
Due to site was thought to be in kidney	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward J. Merritt M.D.
M. D. or other

Address Cambrills Md Date signed 8-29-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07397

83a

CERTIFICATE OF DEATH

Reg. Diat. No.....

1. PLACE OF DEATH:

County: A. A. Co.

City or town: Pint Pleasent

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Pint Pleasent

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME: Frank Bradley

3. (b) Social Security Number: 216-05-3283-A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife: Mable

8.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.): 1879

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
69				

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Foreman

11. Industry or business

FATHER — 12. Name: Frank Bradley

13. Birthplace: Baltimore ?

MOTHER — 14. Maiden name.....

15. Birthplace: Baltimore

16. Informant: Mable Bradley

Address: Box 231 Pt. Pleasent

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 26th 1948 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: A. A. Co. Md.

18. Funeral director: B. L. Harle

Address: 900 S. Paca St.

19. 8/25 19 48 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 23rd 1948 at 11.4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 1947 to August 1948

and that I last saw him alive on August 21 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage (Massive)	4 days.
Due to: Arterio Sclerosis	Unknown.
Due to: Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE: John F. Alexander M. D.

Address: Ten Lunie Md. Date signed: 8/26/48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1948
− 69
1879

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08005

170c

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 4 hours
Hospital, Institution, or street address where death occurred: Annapolis Emergency Hospital
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington (If outside city or town limits, write RURAL and give nearest town)
Street No.: 1356 - E street - SE (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Paul Branson

3. (b) Social Security Number: 579-24-4983

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jany 29 1926

8. AGE: Years: 22 Months: 8 Days: 6 If less than one day: hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Plumber
11. Industry or business: Plumbing

FATHER
12. Name: Fred. Branson
13. Birthplace: Wash. D.C.

MOTHER
14. Maiden name: Lulu Haynes
15. Birthplace: West Virginia

16. Informant: Fred. Branson
Address: 1356 E. St., SE, Washington, D.C.

17. (Burial, cremation, or removal. Which?) Removal Date thereof: Aug 29-1948 (month) (day) (year)
Cemetery or crematory:
Location: Washington D.C.
18. Funeral director: W. W. Chambers & Co.
Address: Washington D.C.
19. Aug. 29 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 29, 1948, at 9.50 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Postmortem Examination ~~and that I last saw him alive on~~ Aug. 29, 1948

	DURATION
Immediate cause of death: Fracture Skull	
~~Due to~~ Crushed Chest	
~~Due to~~ Hemorrhage	
Other conditions: Fracture st. jaw, Fracture left leg	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 8-29-48
Where did injury occur? near Millersville (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?):
Means of injury: auto. collision Injured at work? no.

23. SIGNATURE: John N. Lafty M.D. Deputy Medical Examiner
Address: Annapolis Md Date signed: 8-29-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

08006

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Mago. Vista (Magothy River)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2304 Lyndhurst
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Alexander B. Brebner

3.(b) Social Security Number: 157-10-7368

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Married

6.(b) Name of husband or wife: Edna Brebner
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 30, 1906

8. AGE: Years	Months	Days	If less than one day
41	1	4	hrs. min.

9. Birthplace: Newport News Va.
(Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Railroad

FATHER
12. Name: Alexander R. Brebner
13. Birthplace: Aberdeen, Scotland

MOTHER
14. Maiden name: Agnes MacKay
15. Birthplace: Aberdeen, Scotland

16. Informant: Mr Alexander R. Brebner
Address: 2304 Lyndhurst Ave, Balto, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 5, 1948 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Brooklyn, Md. R.F.D.

18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md

19. 8/5 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 2 1948, at M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem Examination 19 ~~to~~ ~~and that I last saw h~~ ~~alive~~ on Aug. 4 1948

Immediate cause of death	DURATION
Due to: Drowning	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Aug. 2 1948
Where did injury occur? near Mago-Vista (City or town) A.A. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Magothy River
Means of injury: Drowning Injured at work? No

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 8-4-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08007

932

Reg. Dist. No. 25

1. PLACE OF DEATH: ~~Balto~~ Anne Arundel County

City or town Brooklyn Park (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 144 Edgevale Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: Anne Arundel
(For newborn infants give residence of mother)

State Md. County ~~Balto.~~

City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 144 Edgevale Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war ~~WW~~

3.(a) FULL NAME Esther Burns Brown

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6.(b) Name of husband or wife James S. Brown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 4th 1895

8. AGE: Years	Months	Days	If less than one day
52	8	8	..... hrs. ..... min.

9. Birthplace N. J. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER 12. Name Lewis C. Weldon

13. Birthplace Pa.

MOTHER 14. Maiden name Edith M. Burns

15. Birthplace Pa.

16. Informant James S. Brown

Address 144 Edgevale Rd. - Brooklyn Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/16/48 (month) (day) (year)

Cemetery or crematory Glen Haven

Location Glen Burnie Md.

18. Funeral director William Cook Inc

Address 1217 St. Paul st.

19. ..... 19..... (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12th 1948 at 12:30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 12 1948 to Aug 12 1948 and that I last saw h.. alive on Aug 12 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 hrs.
Due to Hypertension and Arteriosclerosis	10 yrs.
Due to Dementia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE David Bachara M.D.
M. D. or other

Address 1045 Saratoga Ave Date signed Aug 13, 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

08008

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos.
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 3 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 569 Oxford St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3. (a) FULL NAME: FRANCIS BROWN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age: ---
7. Birth date of deceased (mo., day, yr.): 1913

8. AGE: Years: 35 | Months: | Days: | If less than one day: ....hrs. ....min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: ---

FATHER
12. Name: James Brown
13. Birthplace: unknown

MOTHER
14. Maiden name: Julia Brown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 8-16-48 (month) (day) (year)
Cemetery or crematory: Crownsville
Location: Crownsville, Md.

18. Funeral director: Jacob Morgenstern, M. D.
Address: Crownsville, Md.

19. Aug 16 1948 (Date rec'd by registrar) E.T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11 1948 at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 1948 to August 11 1948 and that I last saw him alive on August 11 1948

Immediate cause of death	DURATION
~~Chronic Pro~~	
Due to	
Due to	
Other conditions: Schizophrenia Catatonic Type - known to us since (Include pregnancy within 3 months of death)	5/19/48

Major findings of operations: ---
Date of op. ---
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury --- Injured at work? ---

23. SIGNATURE: Jacob Morgenstern M.D.
M. D. or other
Address: Date signed 8/11/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

The words "chronic pro" should have been erased from the certificate. Dr. Margenstern 9/27/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

US003

28

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years 7 mo. 6 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 4 years 7 mo. 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: -- Co

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6301 Philadelphia Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: CHEETHAM - ROBERT

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Separated

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.):

8. AGE: Years	Months	Days	If less than one day
53 ?			hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER 12. Name: Sandy Cheetham

13. Birthplace: Virginia

MOTHER 14. Maiden name: Unknown

15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: 8/19/48 (month) (day) (year)

Cemetery or crematory: Crownsville State Hospital

Location: Crownsville, Md.

18. Funeral director: Jacob Morgenstern, M. D.

Address: Crownsville, Md.

19. 8/19 48 E.T. Joyce Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6, 1948 at 10:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1940 to August 6, 1948 and that I last saw him alive on August 6, 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	one day
Due to: General Arteriosclerosis known to us since	1/1/40
Due to:	
Other conditions: Paranoid Condition known to us since	1/1/40

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M. D. M. D. or other

Address: Crownsville, Maryland Date signed: 8/7/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08010

108

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Severn, Md. (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Severn, Md. Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Harvey Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: ETHEL ANNIE CHESTER

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Chandler B. Chester

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): December 8, 1890

8. AGE: Years	Months	Days	If less than one day
57	8	18	..... hrs. ..... min.

9. Birthplace: Rochester, N.Y.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Own Home

FATHER
12. Name: Hugh Summers
13. Birthplace: Canada

MOTHER
14. Maiden name: Etta Phillips
15. Birthplace: Canada

16. Informant: Chandler B. Chester
Address: Severn, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 30, 1948 (month) (day) (year)

Cemetery or crematory: Glen Haven Cemetery

Location: Glen Burnie, Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. Aug 30 1948 (Date rec'd by registrar) L. L. Dalbey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26 1948, at 8.10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 1948 to Aug 26 1948

and that I last saw him alive on Aug 26 1948

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to	
Due to Cerebral Hemorrhage	1 week
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Odenton, Md. Date signed: 8/27/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

08011

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos. 12 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 3 mos. 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ----
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2504 McCulloh St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3. (a) FULL NAME: JESSIE COLLICK

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	NEGRO	MARRIED

6.(b) Name of husband or wife: Allen Collick
---- 6.(c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.): October 15, 1892

8. AGE: Years	Months	Days	If less than one day
55	10		..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: ----

FATHER
12. Name: William H. Scott
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary E. Pierce
15. Birthplace: Baltimore, Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/14/48 (month) (day) (year)
Cemetery or crematory: Interstate Memorial Park
Location: Baltimore, Md.
18. Funeral director: Mrs Katie R Williams
Address: 322 N. Schroeder St.

19. 8/13 (Date rec'd by registrar) 19 48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11 19 48 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 1948 to August 11 1948 and that I last saw h.... or alive on August 11 1948

Immediate cause of death	DURATION
General Paresis known to us since	4/16/48
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -----
Means of injury: --- Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D.
M. D. or other
Address: Crownsville, Md. Date signed 8/11/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12-3-48

08012

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:

County: Anne Arundel

City or town: McPherson Station - P.O. Brooklyn 24, 2-
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred: Dorsey Road.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland. County: Prince Georges.

City or town: Bladensburg.
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Bentley Conkel

3.(b) Social Security Number: 216-07-1035

4. Sex: M.

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of ~~husband~~ or wife: Catherine Peregoy

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.): Aug. 18 - 1883

8. AGE:

Years	Months	Days	If less than one day
64	11	8	hrs. min.

9. Birthplace: Palmer, Illinois
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER

12. Name: Francis M. Conkel

13. Birthplace: Iowa

MOTHER

14. Maiden name: Miami Daniels

15. Birthplace: Illinois

16. Informant: Mrs. Catherine Conkel (wife)

Address: McPherson Station A.A. County

17. B. Date thereof: 8-13-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie Md.

18. Funeral director: James L. McCauley

Address: 136 E. Fort Ave.

19. August 14 1948 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 10 1948, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1948, to Aug. 2 1948

and that I last saw him alive on 8/2/48 19

Immediate cause of death: cerebral hemorrhage — DURATION: 7 hrs.

Due to: ~~automobile accident~~ Jacksonian epilepsy — 2 mos.

Due to: ~~due to cerebral hemorrhage~~ ~~Injury to head - due to automobile accident~~

Other conditions: ~~on 6/16/48~~

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: [12/17/48 akc]

Accident, suicide, or homicide: ~~auto - accident~~ Date of ~~6/16/48~~

Where did injury occur? ~~6/16/48~~ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ~~Crain Highway~~

Means of injury: ~~Automobile accident~~ Injured at work? No

23. SIGNATURE: Gustave H. Paulsen M.D.
M. D. or other

Address: Glen Burnie Md. Date signed: 8/10/48.

VS A15 9-45-15M

Cause of death
Letter 19-8-48.

4063
6106

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08013

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ mos.

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Leonard Lee Cooley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Otee Cooley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 30, 1911

8. AGE: Years	Months	Days	If less than one day
37	6	13	..... hrs. ..... min.

9. Birthplace: Atlanta, Georgia (Town, county, and state)

10. Usual occupation: Bartender

11. Industry or business

FATHER — 12. Name: George W. Cooley

FATHER — 13. Birthplace: Georgia

MOTHER — 14. Maiden name: Jessie L. Weaver

MOTHER — 15. Birthplace: Atlanta, Georgia

16. Informant: Miss Jessie Mae Cooley

Address: Washington, D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 8-13-48 (month) (day) (year)

Cemetery or crematory

Location: Atlanta Georgia

18. Funeral director: B. L. Hopkins and Son

Address: 170-172 West St Annapolis Md

19. Aug 13 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 12 1948, at 4:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 9 1948, to Aug. 12 1948

and that I last saw h[illegible] alive on Aug. 11 1948

Immediate cause of death	DURATION
Miliary tuberculosis	5 days
Due to: Pulmonary tuberculosis	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. Peyton Ritchings, M.D. M.D. or other

Address: Annapolis, Md. Date signed Aug. 13, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Rural near Talent's Bridge (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infant, give residence of mother)
State: Maryland County:
City or town: Baltimore — 30 (If outside city or town limits, write RURAL and give nearest town)
Street No. 1628 Jackson (If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Houston Creighton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 12th 1911

8. AGE: Years 37 Months 0 Days 22 If less than one day: hrs. min.

9. Birthplace: Cambridge, Maryland (Town, county, and state)
10. Usual occupation: Sgt. U. S. A.
11. Industry or business:
FATHER 12. Name: Harvey Creighton
13. Birthplace: Cambridge, Md.
MOTHER 14. Maiden name: Leila Piggin
15. Birthplace: Cambridge, Md.
16. Informant: Clarence Creighton
Address: 703 E. Biddle St. Balto. Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: July Aug 4th 1948 (month) (day) (year)
Cemetery or crematory:
Location: Washington D C.
18. Funeral director: Wastler Funeral Home
Address: 301 E. Capital St. Washington D C.
19. Aug 4 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 3, 1948 at 6 00 P. M.
21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Postmortem Examination to Aug. 3 1948
~~and that I last saw h~~ alive on
Immediate cause of death: Fracture 9 week — DURATION
Due to: Fracture of Skull at base
Due to: Crushed Chest
Due to: Hemorrhage
Other conditions: Comp. fracture left forearm
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 8-3-48
Where did injury occur: Rural (City or town) Anne Arundel (County) Md (State)
Injured at home, farm, industry, public place (where?) Highway #301
Means of injury: auto-truck collision Injured at work? no

23. SIGNATURE: John M. Cleffy M.D. M. D. or Coroner
Address: Annapolis, Md. Date signed 8-3-48

Deputy Medical Examiner

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08015

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

CERTIFICATE OF DEATH

Reg. Diat. No. 26

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Deale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? September 1946

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel County

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thomas Francis Hall Darnall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna M. Darnall

Oct. 21 1883 — 6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years	Months	Days	If less than one day
64			hrs. min.

9. Birthplace: Washington DC (Town, county, and state)

10. Usual occupation: Retired Carpenter

11. Industry or business

FATHER

12. Name: Clayton Nicolas Darnall

13. Birthplace: Maryland

MOTHER

14. Maiden name: Mary Cross

15. Birthplace: Maryland

16. Informant: Ruth M. Olson - daughter

Address: 1721 Fort Davis St. S.E.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Aug 9 1948 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Wash. D C

18. Funeral director: J. Frank Day No. 741

Address: 5406 - 8th Ave. New Washington D.C.

19. Aug 6 1948 (Date rec'd by registrar) S.B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 Aug 1948, at 7 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13 1948, to 6 Aug 1948

and that I last saw him alive on 6 Aug 1948

	DURATION
Immediate cause of death: Cardiac Decompensation	4 mos
Due to: Hypertension	Unk
Due to: Arteriosclerotic Cardio-Vascular-Renal Disease	Unk
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert B. Asser M. D. or other

Address: Upper Marlboro MD Date signed: 7 Aug 48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08016

50

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:
County 106 Church St.
City or town A. A. Co., Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A. Co.
City or town Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 106 Church St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Stanislawa Dronskiewicz

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Thomas
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
70			..... hrs. ..... min.

9. Birthplace Poland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER 12. Name Felix Ordakowski
FATHER 13. Birthplace Poland

MOTHER 14. Maiden name ?
MOTHER 15. Birthplace Poland

16. Informant Lucia Steger
Address 106 Church St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 11-48 (month) (day) (year)
Cemetery or crematory Holy Cross Cem.
Location A. A. Co., Md.
18. Funeral director Wm. S. Fialkowski
Address 2007 Eastern ave

19. August 9 1948 A. W. Hedrick Registror
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1948 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to 8.7 1948
and that I last saw h alive on 1948

Immediate cause of death	DURATION
Generalized Carcinomatosis	8 months
Due to Carcinoma of right breast	
Due to	
Other conditions Hypertensive Cardiovascular Desease.	2

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Henry J. Summers M.D.
M. D. or other
Address 1045 Patapsco Ave Date signed 8.8.48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1948
70
1878

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

08017

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severna Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? several hours
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2232 West Lexington
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Emile Oscar Frederick

3.(b) Social Security Number: 215-10-9315

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widower

6.(b) Name of ~~husband or~~ wife: late MINNIE (KAES)
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby. 18, 1877

8. AGE: Years: 71 Months: 5 Days: 27 If less than one day: hrs. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: woodworker

11. Industry or business: same

FATHER
12. Name: GUSTAV FREDERICK
13. Birthplace: GERMANY

MOTHER
14. Maiden name: —
15. Birthplace: GERMANY

16. Interment: MISS LILLIAN FREDERICK
Address: 2232 W. LEXINGTON ST

17. BURIAL ENTOMBMENT Date thereof: AUG. 18 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: LORRAINE PK MAUSOLEUM
Location: WOODLAWN, MD

18. Funeral director: Harry A Gelke
Address: 7101 Edmondson Ave

19. 8/17/48 [signature]
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 15, 1948, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Postmortem Examination ~~and that I last saw him alive on~~ Aug. 15, 1948

	DURATION
Immediate cause of death	
Due to: Coronary occlusion	
Due to: Coronary sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner
M. D. or Other
Address: Annapolis, Md. Date signed: 8-15-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

SURNAME: EVIDENCE FILMED G117 9-1-48 LL

08018

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 29

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico County

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. ----

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME

HERBERT ~~GAYLIS~~ ~~(Gayles)~~ GALE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age ----- years

7. Birth date of deceased (mo., day, yr.): 1898

8. AGE: Years: 50 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: ~~York~~ Salisbury, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ----

FATHER

12. Name: Samuel ~~Gayles~~ Gale

13. Birthplace: Quantico, Md.

MOTHER

14. Maiden name: Theresa Evans

15. Birthplace: Quantico, Md.

16. Informant: Hospital Records

Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/1/48 (month) (day) (year)

Cemetery or crematory: --

Location: Wicomico County, Md.

18. Funeral director: James F. Stewart

Address: 402 E. Church St., Salisbury, Md.

19. 8/30 48 E.F. Joyce Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 28 19 48, at 11:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 14 19 48 to August 28 19 48 and that I last saw him alive on August 28 19 48

	DURATION
Immediate cause of death: General Paresis	
known to us since	8/14/48
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of ----

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----

Means of injury ---- Injured at work? ----

23. SIGNATURE: Jacob Thorgersen M.D. M. D. or other

Address: Crownsville, Md. Date signed 8/28/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08019

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 243 North Eden St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME

JACK GRAY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Beatrice Gray

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): Dec. 14, 1904

8. AGE: Years: 43 | Months: | Days: | If less than one day: ... hrs. ... min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Tailor

11. Industry or business: ---

FATHER

12. Name: John Gray

13. Birthplace: unknown

MOTHER

14. Maiden name: Elise Gray

15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/11/48 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Baltimore, Maryland

18. Funeral director: Elroy O. Wilson

Address: 1510 Orleans St., Baltimore, Md.

19. 9/9 19... [illegible] Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26 19 48, at 6:16 p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 7 19 48, to August 26 19 48

and that I last saw h... im ... alive on August 26 19 48

Immediate cause of death	DURATION
General Paresis	8/7/48
known to us since	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.: ---

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Jacob Morgenstern M.D. M. D. or other

Address: Crownsville, Md. Date signed 8/26/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

08020

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

186a

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 204 King George St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: MARY GRIFFIN
3. (b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: John Griffin
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): ?? ??, 1864
8. AGE: Years 84 Months ?? Days ?? If less than one day ... hrs. ... min.
9. Birthplace: Ireland (Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name: Patrick Grant
13. Birthplace: Ireland

MOTHER
14. Maiden name: Catherine Lannan
15. Birthplace: Ireland

16. Informant: Mrs. Catherine Grunt
Address: 204 King George St. Annapolis, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-4-48 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: Annapolis, Maryland
18. Funeral director: Ben L. Hopping and Son
Address: 170-172 West St. Annapolis, Maryland
19. August 4 1948 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1st 1948, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12th 1948, to Aug 1st 1948 and that I last saw her alive on July 31st 1948

	DURATION
Immediate cause of death: Pneumonia Broncho	3 day
Due to: hypostasis	
Due to: bedridden because of contusion of hip	3 wks
Other conditions: arteriosclerosis (Include pregnancy within 3 months of death)	

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: July, 1948
Where did injury occur? Annapolis (City or town) (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Fall down steps Injured at work?

23. SIGNATURE: Edith Rodley M.D. or other
Address: 42 State Circle, Annapolis, Md Date signed: 8-3-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08021

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County: a. a.

City or town: Hanover

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: Elkridge Landing Rd.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: a. a.

City or town: Hanover

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Elkridge Landing Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Irene Hammond

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	col.	married

6.(b) Name of husband or wife: Aulbian Hammond

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): Nov. 23 - 1897

8. AGE: Years	Months	Days	If less than one day
50	10		..... hrs. ..... min.

9. Birthplace: Hanover (Town, county, and state)

10. Usual occupation: H. W.

11. Industry or business

FATHER — 12. Name: John Jackson

13. Birthplace: Va

MOTHER — 14. Maiden name: Fanny Gaither

15. Birthplace: Md.

16. Informant: Aulbin Hammond

Address: Elkridge Landing Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 8-48 (month) (day) (year)

Cemetery or crematory: St. Rest. a. a. Co, Md

Location:

18. Funeral director: James A Sayes

Address: 142 W. 3rd St

19. (Date rec'd by Registrar) Aug 5 19 48 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 4 1948 at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1938, to Aug. 4 1948 and that I last saw h alive on Aug. 4. 1948

Immediate cause of death	DURATION
Cardio-Vascular Disease	2 mos.
Due to: Arterio sclerosis	5 yr.
Due to: Hypertension	10 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Chas. L. Bare M. D. or other

Address: Linthicum Date signed 8-4-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08022

47d

Reg. Diat. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Annapolis Emergency Hospital

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 College Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Walter Haste

3.(b) Social Security Number 214-51-976

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	c	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 10 1900

8. AGE: Years	Months	Days	If less than one day
48	7	18	..... hrs. ..... min.

9. Birthplace Annapolis, A A Co.

(Town, county, and state)

10. Usual occupation Railroad

11. Industry or business

FATHER

12. Name Horace Haste

13. Birthplace Skidmore, Md.

MOTHER

14. Maiden name Mary Harris

15. Birthplace Annapolis, Md.

16. Informant Mrs. Hammie Johnson

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 1 1948 (month) (day) (year)

Cemetery or crematory Cemetery

Location West St.

18. Funeral director William Reese, II

Address 108 Washington St.

19. Sept. 1 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 August 1948 at 800 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 July 1948 to 28 August 1948

and that I last saw him alive on 28 August 1948

Immediate cause of death	DURATION
Carcinoma of lungs.	6 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations no operation performed

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H. Hooker, M.D. M. D. or other

Address 53 Cumbell St. Cumberland, Md. Date signed 1 Sept 48.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

132

08023

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: A A Co

City or town: Wilson Town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Wilson Town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Martha Hawkins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Col	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 63 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Laurel, Md. (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name Tent Williams

FATHER 13. Birthplace Laurel md

MOTHER 14. Maiden name

MOTHER 15. Birthplace

18. Informant Mamie Rollins

Address A A Co

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 29 48 (month) (day) (year)

Cemetery or crematory Fork Church

Location A. A Co

18. Funeral director M. Thadeus Jones

Address Bowie Md

19. 8/26 1948 E. F. Joyce Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1948 at 330 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1st 1946 to 8-25 1948 and that I last saw h[illegible] alive on Aug 23 1948

Immediate cause of death	DURATION
Acute dilatation of the heart	3 days
Due to Nephritis with Asthma	2 yrs
Due to Brights disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE O. H. Mac Namara M. D.

Address Mitchellville Md Date signed

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08024

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

21

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: A. A.

City or town: Severn Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Severn
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Near Odenton
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Bernice V Hines

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: James S. Hines

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 6. 1877.

8. AGE:

Years	Months	Days	If less than one day
71	6	12	..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Home wife.

11. Industry or business

FATHER
12. Name: Richard Reed - Redmiles

13. Birthplace: Md.

MOTHER
14. Maiden name: Mary Mary Lowman

15. Birthplace: Md.

16. Informant: Mrs. Thomas Redmiles

Address: Telegraph Rd. (Severn Md)

17. Burial, cremation, or removal. Which? Burial Date thereof 8/21/48 (month) (day) (year)

Cemetery or crematory: New Cathedral Cem.

Location: 4500 Old Frederick Rd

18. Funeral director: John J. Lonyan & Son

Address: 901-03 Hollins St.

19. 8-19-48 19.. (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 18 1948, at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 4 1948 to Aug 18 1948 and that I last saw h.e.r. alive on Aug. 18 1948

Immediate cause of death	DURATION
Cerebral Haemorrhage	2 weeks
Due to	
Due to	
Other conditions: Cardio-Vascular Dis	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas. L. Ball Jr. M. D. or other

Address: Linthicum Date signed: 8-18-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

08025

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93C

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Cottage Grove; Pasadena P.O.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Cottage Grove Beach
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Cottage #16
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Leona June Hood

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 4, 1931

8. AGE: Years	Months	Days	If less than one day
17	5	11	..... hrs. ..... min.

9. Birthplace: Baltimore, Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: James H. Hood
13. Birthplace: Balto. Md

MOTHER
14. Maiden name: Leona M. Minnis
15. Birthplace: Balto. Md

16. Informant: Mrs. James H Hood

Address: Cottage Grove Beach (Pasadena) Md P.O

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 18, 1948 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Balto. County

18. Funeral director: Thomas W. Dryden

Address: Glen Burnie, Md.

19. 8-18 1948 (Date rec'd by registrar) L. A. Bleis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15 1948 at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1947, to August 15 1948, and that I last saw her alive on August 14 1948.

	DURATION
Immediate cause of death: Heart Failure	
Due to: Pneumonia, Broncho	7 days
Due to: Rheumatic Cardio-Vascular Disease	2 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Brady Smith M.D. (M. D. or other)

Address: Riviera Beach, Md. Date signed: 8/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct as is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Martin

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08026

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 93 Market Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Charles A. Howard

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth F. Howard

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 17, 1877

8. AGE: Years	Months	Days	If less than one day
71	4	1	hrs. min.

9. Birthplace: Annapolis, Maryland
(Town, county, and state)

10. Usual occupation: Plumber

11. Industry or business

FATHER — 12. Name: John Howard

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Mary Austin

MOTHER — 15. Birthplace: Unknown

16. Informant: Mrs. Elizabeth F. Howard

Address: Annapolis, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-21-48 (month) (day) (year)

Cemetery or crematory: St. Mary's

Location: Annapolis, Md.

18. Funeral director: John B. Taylor & Son

Address: Annapolis, Md.

19. Aug. 21 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 Aug 1948, at 2.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 Aug 1948, to 18 Aug 1948 and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary occlusion	2 hrs.
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Donald H. Howard M.D.
M. D. or other

Address: 53 Cornhill St. Date signed: 20 Aug 48.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15

1. PLACE OF DEATH:

County: A. A. Co.

City or town: Linthicum Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

422 W. Greenwood Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Linthicum Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 422 W. Greenwood Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Joseph Huber

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary M. Huber

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 18, 1872

8. AGE:	Years	Months	Days	If less than one day
	75	11	20	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Operates Bakery Stall

11. Industry or business: Self

FATHER
12. Name: George Jacob Huber
13. Birthplace: Germany

MOTHER
14. Maiden name: Catherine Webber
15. Birthplace: Germany

16. Informant: Mrs. John H. Heid

Address: Linthicum Heights, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 11, 1948 (month) (day) (year)

Cemetery or crematory: Loudon Park Cemetery

Location: Frederick Rd. Baltimore, Md.

18. Funeral director: Wm. J. Tickner & Sons, Inc.

Address: North & Pennsylvania Ave.

19. 8/9 19 48 (Date rec'd by registrar) D. A. Heduck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8 19 48 at 2 16 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 8 - DEAD ON ARRIVAL 19 ..... to 19 .....

and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Cardiac failure!	
Due to: Coronary occlusion	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: F. X. Paul Tinker M. D. or other

Address: Glen Burnie, Md. Date signed 8/8/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173 08026

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County:
City or town: Kingston
(If outside city or town limits, write RURAL and give nearest town)
Street No. 235 Zerbey Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: HYDOCK, Charles Thomas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Single

6.(b) Name of husband or wife: Not married
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-28-23

8. AGE:

Years	Months	Days	If less than one day
25	4	27	hrs. min.

9. Birthplace: Plymouth, Pa.
(Town, county, and state)

10. Usual occupation: US Navy

11. Industry or business

FATHER
12. Name: Not available
13. Birthplace

MOTHER
14. Maiden name: Not available
15. Birthplace

16. Informant: US Navy records
Address

17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof 8-27-48 (month) (day) (year)
Cemetery or crematory
Location To KINGSTON, Pa.

18. Funeral director: B.L. HOPPING & SON
Address 170-172 WEST ST ANNAPOLIS Md.

19. Aug. 27 1948 (Date rec'd by registrar) Wm. Francis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 August 1948 19 at about 2 45 P. M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem Examination 19 ~~and that I last saw him alive on~~ Aug. 25 19 48

Immediate cause of death	DURATION
Shock	
Due to Hemorrhage	
Due to Multiple fractures of skull, chest & extremities	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? accident Date of 8-25-48
Where did injury occur? near Annapolis (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) E.E. Bishop's Farm
Means of injury air plane collision Injured at work? no

23. SIGNATURE: John M. Caffey, M.D. Deputy Medical Examiner
M. D. or other
Address: Date signed:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

08023

83a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: A.A. Co.

County

City or town Annapolis Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred Emergency Hospital-Annapolis, Md.

How long in hospital or institution? Since Aug 23, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infant give residence of mother)

State Maryland County A.A. Co

City or town Woodland Beach (If outside city or town limits, write RURAL and give nearest town)

Street No. Woodland Beach (If rural, give LOCATION)

2.(a) If veteran, name war

3. FULL NAME Bertha L. Johnson

3.(b) Social Security Number

4. Sex F.

5. Color or race W

6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Joseph M. Johnson (Deceased)

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) May 6, 1893

8. AGE: Years 55 Months 3 Days 19 If less than one day — hrs. — min.

9. Birthplace Loudon Co-Va. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name Wilbur Lee Wortman

13. Birthplace Loudon Co-Va

MOTHER 14. Maiden name Mary Jane Jones

15. Birthplace Fairfax Co-Va

16. Informant Sister Mrs. Ed. J. Deibel

Address 3400 - 22nd St. N.E. Wash D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 8-25-48 (month) (day) (year)

Cemetery or crematory

Location Washington, D.C.

18. Funeral director S.H. Hines Company

Address Washington, D.C. - 2901 14th St. N.W.

19. Aug. 25 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1948, at 2:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 23, 1948, to Aug 25 1948

and that I last saw her alive on Aug 25, 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage (Rt. Side)	Since 8/23/48
Due to Essential Hypertension	
Other conditions (None)	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Albert L. Anderson M.D. M. D. or other

Address Annapolis, Md. Date signed 8/25/48

I

VS A15 9-45:15M

Evidence for change of birth date shown on:

FILM No. G 117 SEP 16 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

08030

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year 20 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 year 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME
BERT JONES

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1887 1867

8. AGE: Years	Months	Days	If less than one day
81			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business
FATHER 12. Name: Garry Jones
13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. burial (Burial, cremation, or removal. Which?) Date thereof 9/7-48 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md
18. Funeral director: Supt Hospital
Address: Crownsville Md
19. 9/7 48 E F Joyce Local Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 28, 1948, at 7:35 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 28 1948 to August 28, 1948
and that I last saw him alive on August 28 1948

	DURATION
Immediate cause of death: General Paresis	8/8/48
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---- Date of: ---
Where did injury occur? ---- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ---- Injured at work?

23. SIGNATURE: Jacob Brongelstein M.D. M. D. or other
Address: Date signed:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

BC 08031

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92a

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County --

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 208 Biddle St. (If rural, give LOCATION)

2.(a) If veteran, name war --

3. (a) FULL NAME JAMES JONES

3. (b) Social Security Number

4. Sex Male

5. Color or race Negro

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Emma Jones

6.(c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) January 10, 1891

8. AGE: Years 57 Months Days If less than one day ... hrs. ... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business —

FATHER 12. Name John Jones

13. Birthplace Virginia

MOTHER 14. Maiden name Cripy Jones

15. Birthplace Maryland

16. Informant Hospital Records

Address Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/3/48 (month) (day) (year)

Cemetery or crematory Mt. Calvary

Location Anne Arundel County, Md.

18 Funeral director Adolphus Halstead

Address 918 Druid Hill Ave., Balto., Md.

19. 9/2 (Date rec'd by registrar) 1948 R.W. Hedrick Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1948, at 1:00 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 24 1948 to August 30 1948 and that I last saw him alive on August 30 1948

Immediate cause of death Exhaustion Delirium known to us since — DURATION 8/24/48

Due to

Due to

Other conditions Aortic Insufficiency known to us since 8/24/48 (Include pregnancy within 3 months of death)

Major findings of operations ---- ---- Date of op. ---

Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ---- Date of ----

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE Jacob Morgenstern M.D. M. D. or other

Address Crownsville, Md. Date signed 8/30/48

08032

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

107

Reg. Diat. No. 2.1

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Unknown

Hospital, Institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 20 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ~~Annapolis~~ Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. Wright's Hotel - Calvert St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John P. Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 1906

8. AGE: Years	Months	Days	If less than one day
42	7		..... hrs. ..... min.

9. Birthplace Davidsonville, Md., A. A. Co. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Thomas Henry Jones

FATHER 13. Birthplace Md.

MOTHER 14. Maiden name Ella Jones

MOTHER 15. Birthplace Md.

16. Informant Cornelia Garrett

Address Spa Road, Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 25, 1948 (month) (day) (year)

Cemetery or crematory Davidsonville, Md

Location Davidsonville, Md.

18. Funeral director J. B. Johnson

Address Annapolis, Md. P.O. Box 462

19. Aug 25 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23, 1948 at 12 PM

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ..... 19.. to 19..

and that I last saw h.. alive on ..... 19..

Immediate cause of death	DURATION
Cardiorespiratory failure	
Due to Broncho Pneumonia	
Due to Exposure + Malnutrition	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE E. Peyton Ritchie, M.D. Acting M.E. for other

Address Annapolis, Md. Date signed Aug. 23, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

08033

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County Anne Arundel
City or town Woodland Beach, Edgewater
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Woodland Beach, Edgewater
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Jacob Andrew Kerns

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W.	Widower

6.(b) Name of husband or wife: Elizabeth A. Elkins
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): October 8, 1857

8. AGE: Years	Months	Days	If less than one day
90	10	17	... hrs. ... min.

9. Birthplace: Paris, Faulkier Co. Va. (Town, county, and state)
10. Usual occupation: Masonry contractor
11. Industry or business: Masonry

FATHER
12. Name: Marshall Kerns
13. Birthplace: Va.

MOTHER
14. Maiden name: Katie Jarmon
15. Birthplace: Va.

16. Informant: Mrs. H.S.Slocombe
Address: Woodland Beach, Edgewater, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/28/48 (month) (day) (year)
Cemetery or crematory: Warrenton
Location: Warrenton, Va.

18. Funeral director: T.A.Hardesty & Son
Address: Galesville, Md.

19. Aug 27, 1948 (Date rec'd by registrar) Edward Collemon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 25 1948, at 9:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 13 1948 to Aug 25 1948 and that I last saw h[illegible] alive on Aug 23 1948

Immediate cause of death: Arteriosclerosis
Cerebrovascular disease
& hypertension — DURATION: 2 yrs.

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: S. Bernard Neff M. D. or other
Address: Annapolis Md Date signed 8/26/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

08034

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mos. 16 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 7 mos. 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 605 N. Carrollton Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME

WILBER H. LAYTON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Janette Layton

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1907

8. AGE: Years	Months	Days	If less than one day
41			...hrs. ...min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business: ---

FATHER
12. Name: Wilber Layton
13. Birthplace: Martinsburg, W. Virginia

MOTHER
14. Maiden name: Eva Layton
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 28, 1948 (month) (day) (year)

Cemetery or crematory: Mt. Auburn Cem.

Location: Westport, Balto.

18. Funeral director: Chas G. Cooper

Address: 512 N. Carrollton Ave.

19. 8/26 (Date rec'd by registrar) 19 48 A. W. Hedrick W.H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 24 19 48 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 9 19 48 to August 24 19 48 and that I last saw him alive on August 24 19 48

Immediate cause of death: General Paresis — DURATION: 1/9/48

known to us since

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: ---

Date of op.: ---

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Jacob Morgenstern M. D.

M. D. or other

Address: Crownsville, Maryland Date signed: 8/24/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08035

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis-on the Bay
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3928 Livingston N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: No.

3.(a) FULL NAME: Charles Brown Lingamfelter Sr.
3.(b) Social Security Number: no-

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Ruth M. Lingamfelter
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): May 26, 1886

8. AGE:

Years	Months	Days	If less than one day
62	2	12	hrs. min.

9. Birthplace: Martinsburg West Virginia
(Town, county and state)
10. Usual occupation: Retired
11. Industry or business: U.S. Treasury Dept

FATHER
12. Name: ~~Jacob H.~~ Charles Jacob Lingamfelter
13. Birthplace: Berkley Co. West Virginia

MOTHER
14. Maiden name: Anna Small
15. Birthplace: Martinsburg West Virginia

16. Informant: Mrs. Ruth M. Lingamfelter
Address: 3928 Livingston St. N.W. Wash. D.C.

17. Removal. Date thereof: 8-7-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory:
Location: Bethesda, Maryland

18. Funeral director: Wm R. Pumphrey
Address: Bethesda Maryland

19. Aug 7 1948
(Date rec'd by registrar)
~~Wm R. Pumphrey~~
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 7 1948, at 11 A.M.

21. I CERTIFY that death occurred on the date above given: ~~that I last attended deceased from~~
Post mortem Examination
~~and that I last saw deceased on~~ Aug. 7. 1948

Immediate cause of death	DURATION
Due to: Coronary Embolism	sudden
Due to: Coronary Sclerosis	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John N. Claffy M.D. Deputy Medical Examiner
M. D., or Other
Address: Annapolis, Md. Date signed: 8-7-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08036

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years 4 mos.
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 35 years 4 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: unknown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: BENJAMIN LISBY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): (Unknown) 1873

8. AGE: Years: 75? Months: Days: If less than one day: ...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: ---

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-7-48 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md.

18. Funeral director: Dept. of Hospitals
Address: Crownsville Md.

19. 9/7 1948 (Date rec'd by registrar) E. Flora Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 31 19 48, at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 41, to August 31 19 48
and that I last saw him alive on August 31 19 48

Immediate cause of death	DURATION
Lung Tuberculosis known to us since	4/24/13
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Jacob Mongeuta M.D.
M. D. or other
Address: Crownsville, Maryland Date signed 8/31/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

08037

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

CERTIFICATE OF DEATH

Reg. Dist. No. 25

PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: A. A. Co.
City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yrs.
Hospital, Institution, or street address where death occurred: 8 Second Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8 Second Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ernestina McDonald

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Byrd W. McDonald
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 1, 1882

8. AGE: Years	Months	Days	If less than one day
65	9	26	hrs. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Daniel Besanz
13. Birthplace: Austria

MOTHER
14. Maiden name: Ida Neugebauer
15. Birthplace: Germany

16. Informant: Mrs. Edwin C. Weaver
Address: 702 Winans Way

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 30/48. (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: A. A. Co. Md.

18. Funeral director: Harry H. Wittle.
Address: 4101 Edmondson Ave.

19. aug 30 19 48 C. W. Hufsin Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 27/48. 19 at 12 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st 19 48 to Aug 27 19 48
and that I last saw her alive on Aug 26 19 48

Immediate cause of death	DURATION
Carcinoma. Breast.	
Due to	
Due to	
Other conditions Metastases to both Lungs. Hypostatic Pneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma Breast. Date of op. about April 1942

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John A. Schwenck M. D. or other
Address: 1337 S. Charles St. Date signed: 8/28/48

08038

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Near Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No.: 19 Revell St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Helen Elizabeth McGilvery

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 25th 1917

8. AGE: Years: 31 | Months: 3 | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: New York (Town, county, and state)

10. Usual occupation: Aviator

11. Industry or business: Mgr. Apt. Port.

FATHER — 12. Name: Harry Schmidt

FATHER — 13. Birthplace: Detroit Mich.

MOTHER — 14. Maiden name: Helen Frazer

MOTHER — 15. Birthplace: Detroit Mich.

16. Informant: Harry Schmidt

Address: 19 Revell St. Annapolis Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Aug 28-1948 (month) (day) (year)

Cemetery or crematory: Ft Lincoln

Location: Pris Co Md.

18. Funeral director: John M. Jay Co. Inc

Address: Annapolis Md

19. Aug. 27 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 25 1948 at about 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem Examination ~~to~~ and that I last saw ~~him~~ alive on Aug. 25 1948

Immediate cause of death	DURATION
3rd. degree, burns	
Due to: over entire body	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Aug. 25 1948

Where did injury occur? near Annapolis (City or town) A.A. (County) Maryland (State)

Injured at home, farm, industry, public place (where?): Trumpy's farm

Means of injury: Air-Plane Collision Injured at work? Yes

23. SIGNATURE: John M. Caffy M.D. Deputy Medical Examiner

Address: Annapolis, Maryland Date signed: 8-27-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08039

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos. 13 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 2 mos. 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: — Co.

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 705 Greenwillow St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME: ROBERT LEE McKENNON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Unknown

6.(b) Name of husband or wife: ----

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): (35 yrs. old) 1913

8. AGE:

Years	Months	Days	If less than one day
35			...hrs. ...min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: ---

FATHER

12. Name: Unknown

13. Birthplace: ----

MOTHER

14. Maiden name: Unknown

15. Birthplace: ----

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 8/25-48 (month) (day) (year)

Cemetery ~~or crematory~~ Hospital

Location Crownsville Md

18. Funeral director Asylum Hospital

Address Crownsville Md Local

19. 8/25/48 (Date rec'd by registrar) 19.... E.J. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18, 1948, at 3:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5, 1948, to August 18, 1948, and that I last saw him alive on August 18, 1948.

Immediate cause of death: General Paresis — DURATION: 6/5/48

known to us since

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op.: ---

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------- Date of:

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: --- Injured at work?

23. SIGNATURE: Jacob Marpenter M.D. (M. D. or other)

Address: Crownsville, Maryland Date signed: 8/18/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15 9-45-15M

1948
35
1913

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08040

173

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Harness Creek Nr Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Bishops Farm

Hospital, institution, or street address where death occurred: Bishops Farm

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ~~Anne Arundel~~ Baltimore

City or town: Essex

(If outside city or town limits, write RURAL and give nearest town)

Street No. 27 Glenwood Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: PHILIPH MIHALTIAN

3.(b) Social Security Number: 284-03-7291

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Thelma Mihaltian

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): March 26, 1915

8. AGE:

Years	Months	Days	If less than one day
33	4	31	..... hrs. ..... min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: Air craft Machinic

11. Industry or business

FATHER

12. Name: Peter Mihaltian

13. Birthplace: Ohio

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Mrs. Thelma Mihaltian

Address: 27 Glenwood Rd. Essex, Baltimore Co., Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: August 27 48 (month) (day) (year)

Cemetery or crematory

Location: Canton, Ohio

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, Maryland

19. Aug. 27 19 48 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 25 19 48 at about 2 45 M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post Mortem Examination 19..., ~~and that I last saw h... alive on~~ Aug 25 19 48.

Immediate cause of death	DURATION
Shock	
Due to Hemorrhage	
Due to Comp. Fracture of Skull	
Due to Crushed Chest.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8-25-48.

Where did injury occur? near Annapolis A.A. Maryland (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) E.E. Bishops farm

Means of injury air plane collision Injured at work? Yes

23. SIGNATURE: John M. Claffy M.D. Deputy medical Examiner (M. D. or other)

Address: Annapolis, Md. Date signed 8-26-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700 08041

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 ½ hrs

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 14½ Hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)

Street No. West 5th St.
(If rural, give LOCATION)

2.(a) If veteran, name war: W.W. II

3.(a) FULL NAME: CLYDE WESLEY MORTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Dorothy Morton

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Feb 19, 1919

8. AGE:

Years	Months	Days	If less than one day
29	5	20	____ hrs. ____ min.

9. Birthplace: Lynchburg Va.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER
12. Name: Harry A Morton
13. Birthplace: Va

MOTHER
14. Maiden name: Irene Della Stephens
15. Birthplace: Va.

16. Informant: Mr. Harry A. Morton
Address: 1023 Jackson St. Lynchburg, Va.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 8-9-48 (month) (day) (year)

Cemetery or crematory:

Location: Lynchburg, Va.

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, Md.

19. Aug. 9 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 8 1948 at 9 35 A M

21. I CERTIFY that death occurred on the date above stated [redacted] Post mortem Examination Aug 8 1948

Immediate cause of death	DURATION
Fracture of Skull	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 8-7-48

Where did injury occur? Crownsville (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?) General's Highway

Means of injury: Motorcycle spill Injured at work? No

23. SIGNATURE: John H. Cleary M.D. Deputy Medical Examiner
M. D. or other

Address: Annapolis, Md. Date signed 8-7-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

08042

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs. 3 mos.
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 3 yrs. 3 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ---
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 129 South Caroline St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3. (a) FULL NAME: EMMA MOULTRIE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife: -----

6.(c) If alive, give age: ----- years

7. Birth date of deceased (mo., day, yr.): 1881

8. AGE:

Years	Months	Days	If less than one day
67			hrs. min.

9. Birthplace: South Carolina
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ---

FATHER
12. Name: Richard Schackelford
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Patsy Dunmore
15. Birthplace: South Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 13-1948 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cem.
Location: Baltimore, Md.

18. Funeral director: Elroy O. Wilson
Address: 1000 Bentley ave

19. 8/13 19 48 A. W. Pedrick (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11 19 48 at 4:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 19 45 to August 11 19 48 and that I last saw her alive on August 11 19 48

Immediate cause of death: Organic Brain Disease — DURATION: 5/4/45
known to us since

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ----- ----- Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: --- Injured at work?

23. SIGNATURE: Robt. Marquette M. D.
Address: Crownsville, Maryland M. D. or other
Date signed 8/11/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

08043

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County Anne Arundel
City or town Mayo (Mill Creek)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A. A.
City or town Edgewater
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Audrey Sharp Naylor

3. (b) Social Security Number

4. Sex female | 5. Color or race Color | 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Benjamin Naylor 6.(c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) 1922

8. AGE: Years 26 | Months | Days | If less than one day hrs. min.

9. Birthplace Stovell Md (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name George Sharp

13. Birthplace Unknown

MOTHER 14. Maiden name Agnes Watts

15. Birthplace A-G. Md

16. Informant Agnes Sharp

Address Edgewater Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 8 1948 (month) (day) (year)

Cemetery or crematory Friendship Home

Location Friendship Md.

18. Funeral director F. G. Hardesty & Son

Address Galesville Md.

19. Aug 8 1948 (Date rec'd by registrar) Edward Coleman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1948 at 4 20 P. M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination ~~and that I last saw him alive on~~ Aug 5 1948

Immediate cause of death	DURATION
Accidental Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 8-5-48
Where did injury occur? Mayo (City or town) A.A. (County) Md (State)
Injured at home, farm, industry, public place (where?) Mill Creek
Means of injury Drowning Injured at work? No

23. SIGNATURE John M. Cloffy M.D. Deputy Medical Examiner M. D. or other
Address Annapolis Md Date signed 8-5-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

1948
26
1922

FILM No. G 117 SEP 23 1948 Additional evidence for change of date of death shown on: FILM No. G 117 AUG 23 1948

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 182

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Millersville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: annapolis (If outside city or town limits, write RURAL and give nearest town)
Street No. St. Johns Hospital
96 North West (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Roger Neal

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	colored.	single.

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 31 - 1948

8. AGE: Years — Months — Days 17 If less than one day ..... hrs. ..... min.

9. Birthplace Annapolis, Md. (Town, county, and state)

10. Usual occupation None.

11. Industry or business

FATHER 12. Name William Neal
13. Birthplace Kalesville, A.A. County.

MOTHER 14. Maiden name Eva Maulden
15. Birthplace Davidsonville, Md.

16. Informant Eva Maulden (mother)
Address Millersville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-17-48 (month) (day) (year)
Cemetery or crematory Millersville
Location A.A. Co.

18. Funeral director Wm Neal
Address Millersville Md.

19. 8-17 48 (Date rec'd by registrar) E.F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August July 17 - 1948 at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h — alive on ..... 19.....

Immediate cause of death (Suffocation) — DURATION: Sudden
Due to sleeping with mother.
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 7/17/48
Where did injury occur? Millersville, A.A. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) None
Means of injury sleeping with mother Injured at work? No

23. SIGNATURE Gustave F. Faucher M.D.
Address Glen Burnie Md. Date signed 8/17/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The age is especially important. Physicians: please write the causes of death clearly and legibly.

08045

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County A. A. Co

City or town Annapolis.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Annapolis Emergency Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A. A.

City or town Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)

Street No. 300 Delaware Ave.
(If rural, give LOCATION)

2.(a) ~~If veteran, name war~~ Glen Gardens.

3.(a) FULL NAME BARRY JOSEPH, Baby Boy Newcomb.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	wh	S

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 22, 1948

8. AGE: Years	Months	Days	If less than one day
—	—	—	2 hrs. 0 min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation None.

11. Industry or business

FATHER 12. Name John L. Isaac Newcomb.

13. Birthplace Md.

MOTHER 14. Maiden name Genivieve McDermott

15. Birthplace

16. Informant John L. Newcomb.

Address 300 Delaware Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 23 1948 (month) (day) (year)

Cemetery or crematory Druid Ridge.

Location Pikesville

18. Funeral director Paul E. Chenoweth Jr.

Address 2415-17 Chestnut Ave.

19. 8/23 (Date rec'd by registrar) 19 48 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 19 48 at 3 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 22 19 48 to Aug 22 19 48 and that I last saw h~~im~~ alive on Aug 22 19 48

Immediate cause of death	DURATION
Congenital heart defect (type not determined)	
Due to ~~or~~ & congenital atelectasis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Bonsack MD
M. D. or other

Address Annapolis Md Date signed 8-24-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Severn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days.

Hospital, Institution, or street address where death occurred:

Home - Severn

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural - Severn

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ralph ~~Robert~~ Lee Norris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 23, 1948.

8. AGE: Years	Months	Days	If less than one day
—	—	8	..... hrs. ..... min.

9. Birthplace: Dolson, Va

(Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER — 12. Name: Vernon Norris

FATHER — 13. Birthplace: Gaithersburg, Md

MOTHER — 14. Maiden name: Eliz Young

MOTHER — 15. Birthplace: Frederick Co. Md

16. Informant: Eliz Norris

Address: Severn, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/1/48 (month) (day) (year)

Cemetery or crematory: (Home)

Location: Severn

18. Funeral director: Father

Address: Severn

19. 9/1 (Date rec'd by registrar) 19..... L. J. D'Alba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 31 1948, at 12:00 P. M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased~~ from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Cardiorespiratory failure

Due to: Prematurity

Due to: (6 mos. gestation)

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. Peyton Ritchings M.D.

M. D. or other official

Address: Annapolis, Md. Date signed 9/1/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

08047

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I)

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Conaway
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A. County
City or town: Riva
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William E. Peake

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Olive Peake
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): August 3, 1901
8. AGE: Years 47, Months 0, Days 4. If less than one day ... hrs. ... min.
9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: Special A.A. Co. Police Officer
11. Industry or business:

FATHER
12. Name: Samuel Peake
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Olive Peake
Address: Riva A.A. Co. Md.

17. Removal (Burial, cremation, or removal, Which?) Date thereof: 8-8-48 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.

18. Funeral director: J. Wm. Lee's Sons
Address: 4th & Mass. Ave. N.E. Washington, DC.

19. Aug. 8 1948 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 7 1948, at 8:00 p.m.

21. I CERTIFY that death occurred on the date above stated ~~I attended the deceased from ... 19 ...~~ Postmortem Examination ~~and that I last saw h... alive on~~ Aug. 7, 1948

Immediate cause of death	DURATION
Due to: Coronary Embolism	Sudden
Due to: Coronary Sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 8-7-48
Where did injury occur? Conaway (City or town), A.A. (County), Md (State)
Injured at home, farm, industry, public place (where?) Route #301
Means of injury: Dead when collided with ...

23. SIGNATURE: John M ... M.D. Deputy Medical Examiner M. D. or other
Address: Annapolis, Md Date signed: 8-7-48

3.4.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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08048

CERTIFICATE OF DEATH

Reg. Dist. No. 693

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: ANNE ARUNDEL

City or town: LAUREL RURAL

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14yr 9mo

Hospital, institution, or street address where death occurred:

DISTRICT TRAINING SCHOOL

How long in hospital or institution? 14yr 9mo

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: ..... County: .....

City or town: WASHINGTON, D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 413 5th St NE

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3.(a) FULL NAME: ARTHUR PERSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	S

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 1 - 1945

8. AGE: Years: 3 | Months: 6 | Days: 25 | If less than one day: ..... hrs. ..... min.

9. Birthplace: District Columbia (Town, county, and state)

10. Usual occupation: none

11. Industry or business: .....

FATHER — 12. Name: HOWARD PERSON

13. Birthplace: Rocky Mount, N.C.

MOTHER — 14. Maiden name: FLORINE

15. Birthplace: Blackstone, Va

16. Informant: History of Dist. Tr. School

Address: LAUREL Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 28 1948 (month) (day) (year)

Cemetery or crematory: Parkes Cemetery

Location: Washington, D.C.

18. Funeral director: John T. Stewart

Address: #30 "H" St. N.E., Wash, D.C.

19. Aug 26 1948 (Date rec'd by registrar) Clara Kastleigh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUG. 26 1948 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-22 1946 to AUG 26 1948 and that I last saw h.m. alive on Aug 25 1948

Immediate cause of death	DURATION
CONGENITAL DEBILITY	Life
Due to: Mental Deficiency - Idiot	
Spastic Diplegia	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Richard D Griffith M.D. (M. D. or other)

Address: Laurel Md Date signed: 8-26-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: A. A.
City or town: Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Meadow Creek Rd.
How long in hospital or institution? 3 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 920 W. University Pkwy.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: THOMAS WINTER PUMPHREY, JR.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Ruth Cromwell Pumphrey
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 26, 1884

8. AGE: Years	Months	Days	If less than one day
64	2	5	hrs. min.

9. Birthplace: A. A. Co.
(Town, county, and state)
10. Usual occupation: Real Estate Operator
11. Industry or business:

FATHER
12. Name: Thomas W. Pumphrey
13. Birthplace: A. A. Co.

MOTHER
14. Maiden name: Fannie Grieneisen
15. Birthplace: Va.

16. Informant: Mrs. Ruth Pumphrey
Address: 920 W. University Pkwy.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/2/48 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cem.
Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. Sept 1, 19 48 (Date rec'd by registrar) A W Kyhrd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 31, 19 48 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 30 19 48, to Aug 30 19 48
and that I last saw [illegible] alive on Aug 30 19 48

Immediate cause of death	DURATION
Angina Pectoris	Sudden
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thos H Phillips M.D. or other
Address: 3307 Edmondson Ave. Date signed: Aug 31-48

Evidence for change of age shown on

08050

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

124-b

CERTIFICATE OF DEATH

FILM No. G 117 AUG 20 1948

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Annapolis Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years.

Hospital, Institution, or street address where death occurred: Emergency Hosp. Annapolis, Md.

How long in hospital or institution? 8

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Edgewater, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Anne Arundel County

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Rodney Ray Richardson.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White	~~Widowed~~ Separated

6.(b) Name of husband or wife: Mrs. Mildred Richardson

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Aug. 12, 1900

8. AGE:	Years	Months	Days	If less than one day
	~~47~~ 47	11	29	....hrs. ....min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: Operated Restaurant.

11. Industry or business: Restaurant

FATHER — 12. Name: Frank R. Richardson

FATHER — 13. Birthplace: Ohio

MOTHER — 14. Maiden name: Helen E. Heiley

MOTHER — 15. Birthplace: Erie, Pa.

16. Informant: Helen Miller

Address: 1111, 13th. St. N.W. Wash. D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 12 1948 (month) (day) (year)

Cemetery or crematory: Washington D.C.

Location:

18. Funeral director: Hyson & Sinnal Home

Address: 1300 H St. N.W. Washington D.C.

19. August 12, 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 Aug. 1948, at 8 30 ~~P~~ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 Aug. 1948, to 11 Aug. 1948 and that I last saw him alive on 11 Aug. 1948

Immediate cause of death	DURATION
Hemorrhage	12 hrs.
Due to: Cerebrosclerosis	8 mos.
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.:

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thos. M. Hutchins M.D.

M. D. or other

Address: Feltham, Md. Date signed: 11 Aug. 1948

VS A15 9-45-15M

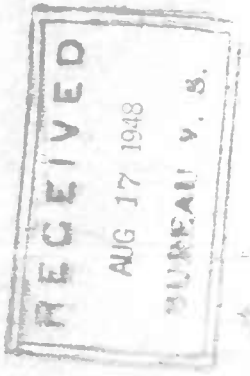
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

West Point

3805

Mrs. Miller



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

08051

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: R 7 D Annapolis - Defense Highway

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address (where death occurred): Rural - Defense Highway nr. Annapolis

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: R 7 D Defense Highway - nr Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Defense Highway

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mathias Rosenauer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Rosenauer

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 8, 1880

8. AGE: Years	Months	Days	If less than one day
68	4	23	hrs. min.

9. Birthplace: Austria - Hungary (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Tobacco grower

FATHER — 12. Name: John Rosenauer

FATHER — 13. Birthplace: Austria - Hungary

MOTHER — 14. Maiden name: Helen Hunt

MOTHER — 15. Birthplace: Austria - Hungary

16. Informant: Mrs. Margaret Rosenauer

Address: R 7 D Annapolis - Defense Highway

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 2 1948 (month) (day) (year)

Cemetery or crematory: St Mary's

Location: Annapolis Md.

18. Funeral director: John M. Taylor Son

Address: Annapolis Md.

19. Sept 1 1948 (Date rec'd by registrar) Wm Branch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 31, 1948 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem Examiner for ~~and that I last saw him alive on~~ Aug. 31 1948

Immediate cause of death	DURATION
Acute Cardiac failure	Sudden
Due to: Hypertensive Heart Disease	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John M. Caffy M.D. Deputy Medical Examiner M. D. or Coroner

Address: Annapolis, Md. Date signed: 8-31-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08052

107

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1115 Court Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Willie May Sappington

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wm. A. Sappington

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 19, 1904

8. AGE: Years	Months	Days	If less than one day
44	7	4	..... hrs. ..... min.

9. Birthplace: Claiborne, Md.
(Town, county, and state)

10. Usual occupation: Employee U.S.N. Academy

11. Industry or business

FATHER
12. Name: Wm. Harrison
13. Birthplace: Md.

MOTHER
14. Maiden name: Maggie Sinclair
15. Birthplace: Unknown

16. Informant: Wm. A. Harrison

Address: 1115 Court Dr. Eastport, Md.

17. Burial — Date thereof 8-25-48
(Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory: Sherwood Cemetery

Location: Sherwood, Md.

18. Funeral director: John M. Laylor & Son

Address: Annapolis, Md.

19. Aug. 25 1948 — Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 23 1948 at 3:58 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 17 1948 to Aug 23 1948 and that I last saw her alive on Aug 20 1948

	DURATION
Immediate cause of death: Acute Myocarditis	5 days
Due to: Bronchial Pneumonia (Bilateral)	6 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: George C. Bond M. D. or other

Address Date signed 8-24-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

08053

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

County: Anne Arundel

City or town: near Annapolis (Sparrows Beach)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? a few hours

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If newborn infant, give residence of mother)

State: Maryland County: 4

City or town: Baltimor
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 929 Madison Ave.
(If rural, give LOCATION)

2(a) If veteran, name war:

3. (a) FULL NAME Clarence Edward Seaborn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 10 1924

8. AGE: Years	Months	Days	If less than one day
24	0	19	hrs. min.

9. Birthplace: Va. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Asbury Seaborn

13. Birthplace: Va.

MOTHER — 14. Maiden name: Annie Boston

15. Birthplace: Va.

16. Informant: Annie Boston

Address: 1127 N. Carolina st.

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Sept. 1 1948 (month) (day) (year)

Cemetery or crematory: Mt Zebulun

Location: A. A.

18. Funeral director: Mrs Rose A Elliott & Daughter

Address: 1129 N. Carolina St. Balto. Md.

19. Aug. 29 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 29 1948 at 1:30 p. M

21. I CERTIFY that death occurred on the date above stated: Postmortem Examination

Aug. 29 1948

Immediate cause of death	DURATION
Drowning	
Due to: Accidental	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date: 8-29-48

Where did injury occur? near Annapolis (City or town) A. A. (County) Maryland (State)

Injured at home, farm, industry, public place (where?): Sparrow's Beach

Means of injury: Drowning Injured at work? no

23. SIGNATURE: John N. Caffy M.D. Deputy Medical Examiner
M. D. or Coroner

Address: Annapolis, Md Date signed: 8-29-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08054

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

111C

Reg. Diat. No. 26

1. PLACE OF DEATH:

County: Ca. Ga.

City or town: Churchton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Ca. Ca.

City or town: Churchton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rurol, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rachael Ann Simmons

3.(b) Social Security Number L

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Charles H. Simmons

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): July 6. 1875

8. AGE: Years 73 | Months 6 | Days 16 | If less than one day: hrs. min.

9. Birthplace: Shady Side Ca. Co. Md. (Town, county, and state)

10. Usual occupation: Home work

11. Industry or business

FATHER 12. Name: Thomas Atwell

13. Birthplace: Unknown

MOTHER 14. Maiden name: Francis Shirley

15. Birthplace: Prince Geo. Co. Md.

16. Informant: Charles H. Simmons

Address: Churchton Md

17. Burial (Burial, cremation, or removal—which?) Date thereof 8-24-48 (month) (day) (year)

Cemetery or crematory: Quaker Camp

Location: Galesville Md.

18. Funeral director: E. A. Hardesty & Son

Address: Galesville Md.

19. Aug 23 1948 (Date rec'd by registrar) J. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 22 1948 at 4:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 48 to Aug 22 1948 and that I last saw h[illegible] alive on Aug 22, 1948

Immediate cause of death: Hypostatic pneumonia — DURATION: 1 day

Due to: Arteriosclerosis — ?

Due to: Senility — ?

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] John M.D. M. D. or other

Address: Shadyside Md. Date signed 8/24/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08055

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 SC

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 21 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 2 yrs. 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 448 E. Federal St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME: LUCY SMITH

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	negro	widowed

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE:

Years	Months	Days	If less than one day
72?			hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ---

FATHER — 12. Name: Major Claiborne

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Lillian Samson

15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 8/19/48 (month) (day) (year)

Cemetery or crematory: Crownsville State Hospital

Location: Crownsville, Md.

18. Funeral director: Jacob Morgenstern, M. D.

Address: Crownsville, Md.

19. 8/19 48 (Date rec'd by registrar) E. T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9 19 48, at 2 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 19 46 to August 9 19 48

and that I last saw her alive on August 9 19 48

Immediate cause of death	DURATION
Chronic Myocarditis	
known to us since	7/19/46
Due to	
Due to	
Other conditions: Senile Psychosis	
Paranoid Condition known to us since 7/19/46	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op. ---

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D. M. D. or other

Address: Crownsville, Md. Date signed 8/9/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170 C

08053

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? several hours
Hospital, institution, or street address (Give name if not in hospital): Annapolis Emergency Hospital
How long in hospital or institution? a few hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town West Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 10 Annapolis
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Samuel William Brewer Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Katherine M. Smith
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 20, 1904

8. AGE:

Years	Months	Days	If less than one day
43	7	21	hrs. min.

9. Birthplace: West Annapolis, A. A. County, Md (Town, county, and state)
10. Usual occupation: Master at Arms
11. Industry or business: U.S. Naval Academy

FATHER
12. Name: Samuel N. Smith
13. Birthplace: Baltimor, Md

MOTHER
14. Maiden name: Frances Estelle Brewer
15. Birthplace: Annapolis, Md

16. Informant: Frederick Norman Smith
Address: West Annapolis, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 - 13 - 48 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: Annapolis, Maryland

18. Funeral director: Ben L. Hopping and Son
Address: 170-172 West St. Annapolis, Maryland

19. Aug 11 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 10 1948, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Postmortem 19 Examination 19
and that I last saw h alive on Aug. 10. 1948

Immediate cause of death	DURATION
Fracture of Pelvis	
Due to Rupture of bladder	
Due to Internal Hemorrhage	
Due to Fracture right forearm	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 8-9-48
Where did injury occur? Weems Creek (City or town) A. A. (County) Md (State)
Injured at home, farm, industry, public place (where?): near Weems Creek Bridge
Means of injury: auto - collision Injured at work? no

23. SIGNATURE: John N. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Date signed: 8-11-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08057

77C

Reg. Dist. No. 21

1. PLACE OF DEATH
County Anne Arundel
City or town Severna Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 yrs
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Pasadena
(If outside city or town limits, write RURAL and give nearest town)
Street No. Junper Hole Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Roger Lee Smoot

3.(b) Social Security Number 212-18-3966

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Ida F. Smoot
Nee, Friese
6.(c) If alive, give age 44 years
7. Birth date of deceased (mo., day, yr.) November 6, 1905

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
42	9	22		

9. Birthplace Near Galestown, Dorchester Co., Md.
(Town, county, and state)
10. Usual occupation Chemist
11. Industry or business Unknown
FATHER 12. Name Homer Smoot
13. Birthplace Dorchester Co., Md.
MOTHER 14. Maiden name Geneva Gordy
15. Birthplace Dorchester Co., Md.
16. Informant Mrs. Geneva Smoot
Address 2204 Penn Ave. West Lawn, Pa.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 31, 1948 (month) (day) (year)
Cemetery or crematory Glen Haven
Location Glen Burnie, Md.
18. Funeral director Thomas W. Singleton
Address Glen Burnie, Md.
19. 8/30 (Date rec'd by registrar) 19 48 L. J. Oakes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 19 48, at 12 30 A. M.
21. I CERTIFY that death occurred on the date above stated, that I attended deceased from ~~[illegible]~~ and that I last saw ~~him~~ alive on Aug. 28 19 48

Immediate cause of death	DURATION
Acute Cardiac failure	
Due to Md. Acute alcoholism	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Caffey M.D. Deputy Medical Examiner
M. D. Coroner
Address Annapolis Md Date signed 8-28-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08058

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severna Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Cedar Crest Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Tyler Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Albertus Starr

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Susan L. Starr
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 26th 1865

8. AGE: Years	Months	Days	If less than one day
82	11		..... hrs. ..... min.

9. Birthplace: Hamilton N.Y. (Town, county, and state)
10. Usual occupation: Ret Florist
11. Industry or business

FATHER
12. Name: Charles Starr
13. Birthplace: N.Y.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs John Buser
Address: Tyler Ave Eastport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 28th 1948 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md
18. Funeral director: John M. Taylor Son
Address: Annapolis Md.
19. Aug. 28 1948 (Date rec'd by registrar) L. A. Blair Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/26/48 19..... at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1948 to 8/26 1948 and that I last saw h.im alive on 8/26/1948

	DURATION
Immediate cause of death: Coronary Thrombosis Acute	
Due to: Coronary Sclerosis	years
Due to:	
Other conditions: Hypertension	years

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: C. J. Mendellis M.D.
M. D. or other
Address: 651 N Bentalou Date signed: 8/26/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 30 L 08059

Reg. Dist. No. 22

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos.

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 3 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: --

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1630 Division Street

(If rural, give LOCATION)

2.(a) If veteran, name war: --

3. (a) FULL NAME

IRA STEPTOE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Magdalin Beau

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1902 - April 8, 1902

8. AGE: Years: 46 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Northumberland Co. Va

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ---

FATHER

12. Name: William Steptoe

13. Birthplace: Northumberland Co. Va

MOTHER

14. Maiden name: Lydia Lowe

15. Birthplace: Northumberland Co. Va

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 24, 1948 (month) (day) (year)

Cemetery or crematory: Macedonia Baptist Church Cem.

Location: Avalon, Va

18. Funeral director: Mrs. George H. Holland

Address: 1631 Druid Hill Ave., Balto.

19. 8/23 1948 (Date rec'd by registrar) R. W. Hedrick DM Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20 1948, at 7:30 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 17 1948 to August 20 1948 and that I last saw him alive on August 20 1948

Immediate cause of death	DURATION
General Paresis known to us since	5/17/48
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury: --- Injured at work?

23. SIGNATURE: Jacob Marquette M.D. M. D. or Other

Address: Crownsville, Maryland Date signed: 8/20/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08060

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95a

CERTIFICATE OF DEATH

Reg. Diat. No. 20.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Davidsonville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 44 yrs

Hospital, institution, or street address where death occurred:

Davidsonville, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Davidsonville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: JAMES VERNON STOCKETT

3.(b) Social Security Number: 218-12-9151

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Helen

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): July 14, 1903

8. AGE: Years	Months	Days	If less than one day
45	1	16	...hrs. ...min.

9. Birthplace: Davidsonville, Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER — 12. Name: James B. Stockett

13. Birthplace: Davidsonville, Maryland

MOTHER — 14. Maiden name: Ida B. Meade

15. Birthplace: A.A. Co., Maryland

16. Informant: Mrs. Anna Helen Stockett

Address: Davidsonville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-5-48 (month) (day) (year)

Cemetery or crematory: All Hallows Cemetery

Location: Davidsonville, Maryland

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, Maryland

19. Sept. 5, 1948 (Date rec'd by registrar) Carrie Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 30 1948; at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1947, to Aug. 28, 1948 and that I last saw him alive on Aug. 28, 1948

Immediate cause of death	DURATION
Acute cardiac failure	
Auricular Fibrillation	14 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John McCarthy M.D. Deputy Medical Examiner

M. D. or other

Address: Annapolis, Md. Date signed: 8-31-48

Child lived 2 hours 30 min.

Birth and Death

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~

Reg. Dist. No. 21

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County Anne Arundel
   City or town Annapolis
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution: Emergency Hospital
   Length of mother's stay in County
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
   State Maryland
   County A. A.
   City or town Annapolis Md.
   (If outside city or town limits, write RURAL and give nearest town)
   Street No. 1502 West
   (If RURAL give LOCATION)

3. Name of child Baby Girl Stokes
4. Date of birth Aug 4 1948 Hour M.
5. Sex F
6. Twin or triplet
7. No. of weeks pregnancy 32

FATHER OF CHILD

8. Full name Samuel S. Stokes
9. Color W
10. Age at time of this birth 36 yrs.
11. Usual occupation Clerk Grocery Store

MOTHER OF CHILD

12. Full maiden name Sarah Bushnell
13. Color W
14. Age at time of this birth 31 yrs.
15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1
    (b) How many other children were born alive but are now dead? (c) How many other children were *born* dead?

17. Did child die before labor? During labor?
18. Pregnancy, complications of
19. Labor: (a) Complications of
    (b) Induced?
20. (a) Was there an operation for delivery? (Yes or No)
    (b) State all operations, if any
    (c) Did child die before operation?
    During operation?

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
    (a) Fetal causes
    (b) Maternal causes

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
    Signature S. Bosworth M.D.
    (Specify if M. D., midwife, or other)
    Address Annapolis Md.

23. (a) Burial (Burial, cremation or removal) (b) Date thereof Aug 5th 48 (month) (day) (year)
    (c) Cemetery or crematory Cedar Hill
24. (a) Funeral director John M. Tayler Inc
    (b) Address Annapolis Md.

25. (a) Aug. 5, 1948 (Date rec'd by registrar) (b) [illegible] (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
    Health Officer, per

V. S. A10

* See Instruction C on stub.

220-22 5306 Loving [illegible]

BC

08062

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: near Elvaton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County:
City or town: Baltimore, Md (If outside city or town limits, write RURAL and give nearest town)
Street No. 2631 Hollins Ferry Rd (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Charles E. Taylor
3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife: Single
6.(c) If alive, give age ...... years
7. Birth date of deceased (mo., day, yr.): Aug 11 1927 ?
8. AGE: Years 21 Months 0 Days 3 If less than one day ...... hrs. ...... min.
9. Birthplace: Balto city Md (Town, county, and state)
10. Usual occupation:
11. Industry or business: Koppers Co
FATHER 12. Name: Charles Taylor
13. Birthplace: Balto
MOTHER 14. Maiden name: Margaret A Seigler
15. Birthplace: Balto
16. Informant: Mother
Address: 2631 Hollins Ferry Rd
17. Burial (Burial, cremation, or removal, Which?) Date thereof: Aug 16-48 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Frederick Rd
18. Funeral director: Edward Foulson
Address: 235 Gwrash Blvd ✓
19. ...... 19 ...... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 13 1948 at 2:48 P.M.
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Postmortem Examination ~~and that I last saw h ...... alive~~ on Aug. 13. 1948

	DURATION
Immediate cause of death:	
Due to: Fracture base of skull	sudden
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings of operations: ...... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 8-13-48
Where did injury occur? near Elvaton (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Highway #2
Means of injury: auto-bicycle Injured at work? No

23. SIGNATURE: John M Caffey M.D. Deputy Medical Examiner (M.D. or other)
Address: Annapolis, Md Date signed: 8-13-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

M

I

08063

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

161a

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 Hrs.
Hospital, institution, or street address where death occurred:
T. H. Johnson Maternity Hosp.
How long in hospital or institution? 20 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 199 Clay St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
~~Baby~~ Thompson, GREGORY MAURICE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			20 hrs. ..... min.

9. Birthplace Annapolis, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Douglass Thompson
13. Birthplace Annapolis, Md.

MOTHER
14. Maiden name Marjorie Brown
15. Birthplace Parole, Md.

16. Informant Marjorie Brown
Address 199 Clay St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 11 48 (month) (day) (year)
Cemetery or crematory Brewer Hill
Location West St. Annapolis, Md.

18. Funeral director William Reese, 11
Address 108 Washington St.

19. Aug. 11 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1948, at 2:30P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 8m 1948, to August 9, 1948 and that I last saw him alive on August 9, 1948

Immediate cause of death	DURATION
Atelectosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Theodore H. Johnson M.D. M. D. or other
Address 40 Northwest Street Annapolis, Md. Date signed 8/10/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

46 b

08064

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: North Severn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Mo
Hospital, Institution, or street address where death occurred:
Kin Kaid Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: N.J. County: Burgan
City or town: Hasbrouck Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 319 Hamilton Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: ALMA TILLBERG

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widwoed

6.(b) Name of husband or wife: John Tillberg
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 23, 1880

8. AGE: Years	Months	Days	If less than one day
68	4	2	hrs. min.

9. Birthplace: Sweeden (Town, county, and state)
10. Usual occupation: —
11. Industry or business

FATHER
12. Name: ? Lind tron
13. Birthplace: S eeden

MOTHER
14. Maiden name: Unknown
15. Birthplace: unknown

16. Informant: Mrs Harry H. Bagley
Address: North Severn (Kin Kaid Rd) Annapolis Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: August 27,48 (month) (day) (year)
Cemetery or crematory
Location: Hasbrouch Heights, N.J.
18. Funeral director: Ben L. Hopping and Son
Address: 170-182 West St. Annapolis, Md
19. Aug 27 19 48 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 25 19 48, at 3 00 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 19 48, to Aug. 25 19 48
and that I last saw h..er alive on Aug. 25 19 48

Immediate cause of death	DURATION
Carcinoma of Stomach	
Due to: with metastasis to liver	
Due to: and Gall-bladder	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Gaffy M.D. M. D. or other
Address: Annapolis Md. Date signed: 8-26-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08065

160 C

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Emergency Hosptial

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Woodlawn Beach
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Edgewarter Post Office
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: RESCOE BRUCE VESTAL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): August 5, 1948

8. AGE: Years | Months | Days | If less than one day: 6 hrs. ____ min.

9. Birthplace: Annapolis, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or Business

FATHER
12. Name: Alton Leo Vestal
13. Birthplace: Washington D.C.

MOTHER
14. Maiden name: Narma D. Fallon
15. Birthplace: Iowa

16. Informant: Mr. A.L. Vestal Father
Address: Edgewarter Post, Office, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 6,48 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Maryland

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, Maryland

19. Aug. 6 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5 1948 at 12 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 5 1948 to Aug 5 1948 and that I last saw h... alive on Aug 5 1948

Immediate cause of death	DURATION
Prematurity	
Due to: Premature separation of placenta	July 29
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ____ Injured at work?

23. SIGNATURE: M. J. Klemans M. D. or other

Address: Annapolis, Md Date signed 8/6/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08066

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 Months
Hospital, institution, or street address where death occurred:
Crownsville State H ospital
How long in hospital or institution? 11 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: --
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 660 W. Mulberry Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: WATSON - LOUIS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): May 4, 1914

8. AGE: Years	Months	Days	If less than one day
34			hrs. min.

9. Birthplace: North Carolina
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: Thomas Watson
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Indie Hooper
15. Birthplace: North Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/16-48 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md

18. Funeral director: Supt. Hospital
Address: Crownsville Md

19. 8/16 48 (Date rec'd by registrar) E.T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 7, 1948, at 5:15A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 6, 1947 to August 7, 1948 and that I last saw him alive on August 7, 1948

Immediate cause of death	DURATION
Due to: General Paresis	
known to us since	10/6/47
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M. D.
M. D. or other
Address: Crownsville, Maryland Date signed 8/7/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

08067

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Pasadena P.O. North Shore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, Institution, or street address where death occurred:
.....
How long in hospital or institution? Earl Davidson

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Maryland County: Baltimore
City or town: Reisters Town
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Bond Rd
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Richard Hilson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife .....
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 11 1921

8. AGE: Years 27 | Months 7 | Days 17 | If less than one day ..... hrs. ..... min.

9. Birthplace: Pontiac Michigan (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business .....

FATHER
12. Name: Fred Hilson
13. Birthplace: Elkton Md.

MOTHER
14. Maiden name: Maria Elyabth Davidson
15. Birthplace: Jamestown Md.

18. Informant: Fred Hilson
Address: Reisterstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 31-48 (month) (day) (year)
Cemetery or crematory: All Saints
Location: Balto Co.

18. Funeral director: J. F. Elline & Sons
Address: Reisterstown Md.

19. 8/29/ 1948 (Date rec'd by registrar) L. J. DeAlton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 28 1948 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended the deceased from~~ Post mortem Examination
~~and that I last saw him alive on~~ Aug. 29 1948

Immediate cause of death	DURATION
Due to: Drowning	
Due to: accidental	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of injury: 8-28-48
Where did injury occur? near Dutchland Ft. (City or town) (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Magothy River
Means of injury: Drowning Injured at work? No

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner
Address: Annapolis, Md Date signed: 8-29-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.